| **Print, Complete and Mail or Fax to:** | |
|---|---|
| New York State Department of Health<br>P.O. Box 2051<br>Empire State Plaza Station<br>Albany, NY 12220-0051<br>(518) 486-2938<br>(518) 474-7381 (FAX) | Approved_____ Date_____<br><br>Disapproved_____ Date_____<br><br>Provider #_____<br><br>Date Notified_____<br><br>Next Renewal Date_____ |

# Provider Reapplication to Administer Infection Control Training Renewal General Information

**General Information**

**Do you intend to continue offering Infection Control Training?** ☐ Yes ☐ No

* If no, please complete lines 1-3 below and submit to the address above.
* If yes, complete all of the reapplication and submit to the address above.

1) Your Provider Number _____ Original Application Date _____

County _____

2) Type of Provider (Check all that apply) ☐ Hospital ☐ Long Term Care

☐ Home Care ☐ Independent CIC ☐ Other _____

3) Original Provider Name (Facility or Organization)
_____

4) New Name, if Applicable _____

5) Address _____

City _____ State _____ ZIP _____

6) Contact Person_____ Title _____

7) Phone _____ FAX _____ E-Mail _____

**Qualifications**

For all Article 28 applicants and renewal applicants such as hospitals, long term care facilities and home care, the **recommended** qualifications for the course work instructors are (check those that apply):

☐ Certification in infection control by the Certification Board of Infection Control and Epidemiology (CBIC), or,

☐ Current experience in infection control.

For non-article 28 applicants and renewal applicants such as organizations and consultants, **the required qualifications** for the course work instructors are (check those that apply):

☐ Current certification in infection control by CBIC, or,

☐ Active in infection control practice within an institution for a minimum of 2 years, or,

☐ Practicing infectious disease physician.

8a) Course Work Instructor:

Name _____

Title _____

Phone _____ FAX _____

E-Mail _____

Degree (check all that apply) ☐ RN ☐ LPN ☐ CIC ☐ MPH ☐ Ph.D ☐ MD

☐ BA ☐ BS ☐ Other_____

8b) Course Work Instructor:

Name _____

Title _____

Phone _____ FAX _____

E-Mail _____

Degree (check all that apply) ☐ RN ☐ LPN ☐ CIC ☐ MPH ☐ Ph.D ☐ MD

☐ BA ☐ BS ☐ Other_____

9) Please check the eligible groups you currently train:

☐ Employees ☐ Credentialed/Affiliated Professionals ☐ Community-based Providers

10) Check the professions which you were previously approved to train:

☐ Physicians
☐ Physician Assistants
☐ Optometrists
☐ Podiatrists
☐ Dental Hygienists
☐ Special Assistants
☐ Licensed Practical Nurses
☐ Registered Professional Nurses
☐ Dentists

11) Would you like to add any new professions to your target audience at this time?

☐ Yes ☐ No

If Yes, please check the groups you wish to add:

☐ Physicians
☐ Physician Assistants
☐ Optometrists
☐ Podiatrists
☐ Dental Hygienists
☐ Special Assistants
☐ Licensed Practical Nurses
☐ Registered Professional Nurses
☐ Dentists

## Terms of Agreement

- The provider agrees that the course work or training will cover the core elements specified in the New York State Department of Health and New York State Education Department's Infection Control Training Syllabus (please call (518) 486-2938 to obtain a copy). The provider agrees that the course work will be tailored to meet the needs of the target audience and will be current, relevant and scientifically accurate.
- The provider agrees that the instructional staff will possess the training, experience, or earned degrees necessary to insure that the educational goals of the program are met.
- The provider agrees to issue a Certificate of Completion to training participants. The format must contain information set forth by the example included in each syllabus. The provider agrees to assume the cost of reproducing this or any other training related material. The provider further agrees to assume the cost of postage, handling, or any other cost associated with communicating with personnel of the Department of Health or complying with directives of this agency.
- The provider agrees to maintain a record of course participants for not less than six (6) years from the date of the completion of the course. These records may be subject to the review of the Department of Health and the provider agrees to make these records available to the Department or its designee(s) during regular business hours. The provider also agrees to respond to inquiries from the Department regarding these documents.
- The provider agrees that the Department of Health may review and evaluate the coursework or training offered and that termination of the provider's approved status may result if the Department determines that the course work is inadequate, incomplete, inaccurate or otherwise unsatisfactory.
- The provider understands and agrees that failure to comply with this agreement may result in termination of the provider agreement by the New York State Department of Health.

Signature of Authorized Official

_____

(Print or Type Name)

_____

(Title)

_____

(Date) _____